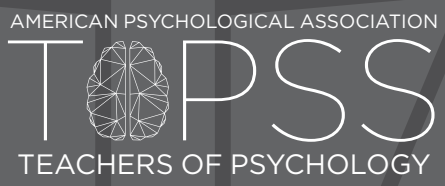
TREATMENT OF PSYCHOLOGICAL DISORDERS

A Six-Unit Lesson Plan for High School Psychology Teachers



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Developed and Produced by the Teachers of Psychology in Secondary Schools (TOPSS) of the American Psychological Association, April 2019

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Treatment of Psychological Disorders
A Six-Unit Lesson Plan for High School Psychology Teachers

This unit is aligned to the following content and performance standards of the *National Standards for High School Psychology Curricula* (APA, 2011):

Domain	Standard Area	Content and Performance Standards	Supporting Documents and Activities
Applications of Psychological Science	Treatment of Psychological Disorders	**Content Standard 1** Perspectives on treatment Students are able to (performance standards): 1.1 Explain how psychological treatments have changed over time and among cultures. 1.2 Match methods of treatment to psychological perspectives. 1.3 Explain why psychologists use a variety of treatment options.	Lesson One Content Outline (1.1, 1.3) Lesson Two Content Outline (1.2) Lesson Three Content Outline (1.2) Lesson Four Content Outline (1.2) Lesson Five Content Outline (1.2) Lesson One Critical Thinking Exercises Activity 1: *Treatment Options* Activity 5.1: *Using Psychological Perspectives To Change Habits* Activity 6: *Choosing a Psychotherapist: Activity and Handout*
Applications of Psychological Science	Treatment of Psychological Disorders	**Content Standard 2** Categories of treatment and types of treatment providers Students are able to (performance standards): 2.1 Identify biomedical treatments. 2.2 Identify psychological treatments. 2.3 Describe appropriate treatments for different age groups. 2.4 Evaluate the efficacy of treatments for particular disorders. 2.5 Identify other factors that improve the efficacy of treatment. 2.6 Identify treatment providers for psychological disorders and the training required for each.	Lesson One Content Outline (2.5, 2.6) Lesson Two Content Outline (2.1, 2.3, 2.4) Lesson Three Content Outline (2.2, 2.3, 2.4) Lesson Four Content Outline (2.2, 2.4) Lesson Five Content Outline (2.2, 2.3, 2.4) Lessons 2, 3, 4, and 5 Critical Thinking Exercises Activity 4: *Empathy: The Cornerstone of Counseling* Activity 5.2: *Treating Psychological Disorders*
Applications of Psychological Science	Treatment of Psychological Disorders	**Content Standard 3** Legal, ethical, and professional issues in the treatment of psychological disorders Students are able to (performance standards): 3.1 Identify ethical challenges involved in delivery of treatment. 3.2 Identify national and local resources available to support individuals with psychological disorders and their families (e.g., NAMI and support groups).	Lesson Six Content Outline (3.1) Lesson Six Critical Thinking Exercises Activity 6: *Choosing a Psychotherapist: Activity and Handout* Resources (3.2)

Proposed number of days/hours for lesson:

Recommended number of teaching hours*: 4 **See Introduction*
5 days in 50-minute classes = 4 hours 3 days in 90-minute classes = 4 hours

This project was supported by a grant from the American Psychological Foundation. The authors thank Lynn Bufka, PhD, of the APA Practice Directorate, Chris Jones-Cage, PhD, of College of the Desert, Melanie Lanz, PhD, of Oklahoma State University, Jennifer Schlicht, MS, of Olathe South High School (Olathe, KS), Steven Turner, MEd, of Albemarle High school (Charlottesville, VA), and Maria Vita of Penn Manor High school (Millersville, PA) for their reviews of this resource.

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PROCEDURAL TIMELINE

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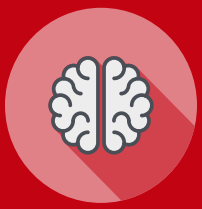
INTRODUCTION



Students in a high school psychology course are, for the most part, fascinated by the abnormal psychology units, both the descriptions of the disorders, as well as the treatment options presented in the units. It is always wise to stress that we are all students of the science of psychology, not psychologists! As case studies are presented in class, be sure to stress that clinicians do not diagnose clients on the basis of a brief description; that case studies are used in class to have an overview of a wide variety of disorders. It is also important to alert students to the impact of labeling people as having a psychological disorder — stigmas are real and hurtful. For this reason, it is harmful to ever use role playing in your classes. Undoubtedly, there are students diagnosed either with the disorder or with a family member who has been diagnosed with the disorder in your class and therefore, role playing any disorder is inappropriate.

This lesson plan contains content outlines with terms and appropriate content for the high school psychology class as well as critical thinking exercises. Classroom activities and resources are provided together at the end of the lesson plan. The activities for this lesson are to be taken as recommendations. More than four hours of instructional activities have been included in this resource. As such, teachers are encouraged to be flexible in choosing which activities to use and which ones might be better left unused given time constraints. Additionally, teachers are encouraged to modify any suggested activity to make it fit well with the needs of the students. New teachers especially may want to focus on the terms and names provided in bold font in this lesson plan. These key terms and figures highlight important parts of the content to present to students in class.

Teachers have the choice and option of teaching the abnormal and treatment units together. In this lesson plan, the authors have incorporated the DSM-5 to assist in the teaching of abnormal behavior.

CONTENT OUTLINE

LESSON 1

Perspectives on Treatment

This lesson covers the history of treatment of mental illnesses. Treatment professionals with specialized training in mental health are introduced, and important background information is provided for understanding treatment approaches in the larger context of the therapy relationship and the research literature.

PERSPECTIVES ON TREATMENT

History of treatment of the severely mentally ill

Historically, with rare exceptions, treatment ranged from lack of care to extreme and often violent mistreatment of individuals with serious psychological disorders. Documented exceptions were seen in China for several centuries and in Islamic countries in the Middle East during what were the 'dark ages' in Europe. **Avicenna of Persia** (c. 980-1037), a physician, was a major figure in humane treatment of the mentally ill during this time. (Butcher, Hooley, & Mineka, 2014).

Early Western treatment approaches (circa 1300–1900)—early psychological treatment consisted primarily of imprisonment, rather than specific techniques to help people with mental illness. **Bethlam** (or the more common name of Bedlam) is located in London and is considered the oldest hospital caring for people with mental illness. The term *bedlam* aptly describes the conditions that were present in hospitals at that time. Treatment facilities, called asylums or mental hospitals, were built to house people with mental illness in the mid-1500s. Patients often were chained and mistreated in the early attempts to treat psychological illness.

In France, **Phillipe Pinel** (1745–1826) was the first physician to remove the chains from seriously mentally ill patients, which resulted in calmer patients. In the United States in the early 1800s, the 'moral management' movement promoted humane treatment that consisted of structured physical labor, spiritual discussion, and attention to social needs. This treatment was, perhaps surprisingly, effective at restoring patients to life outside of institutions (Butcher et al., 2014, p. 38). In the 1840s, in the United States, **Dorothea Dix** (1802–1887) also initiated freeing the mentally ill from mistreatment in jails and other locations. She was instrumental in helping to establish state-funded mental hospitals (Weiten, 1994) as sites for humane treatment.

The precursor to modern psychotherapy began with a physician, **Josef Breuer** (1845–1925), who used hypnosis to get his patients to talk about their problems in what became known as cathartic therapy (talk therapy) (Sternberg, 1995).

Contemporary treatment approaches (1900–2000)

Despite social movements for humane treatment, early twentieth century treatments still included harsh medical interventions (e.g., shock treatments, prefrontal lobotomy)

which were performed in mental hospitals. In the 1950s and 1960s, thanks in part to the discovery of some useful medications, efforts were undertaken to close many large mental hospitals.

Deinstitutionalization resulted in release of many patients, who were then supposed to receive treatment in the community with medications and outpatient services provided in community mental health centers. Unfortunately, resources have not been able to keep up with the needs of the severely mentally ill (Butcher et al, 2014), many of whom are now incarcerated or among the homeless.

Treatment of severe psychological disorders now includes hospital inpatient treatments, community mental health or other outpatient treatments, and a hybrid inpatient-outpatient treatment called "day treatment."

History of psychotherapy

Several theories about the origins of psychological disorders emerged in the twentieth century, and specific treatments were introduced that corresponded with these theories. Freud's (1856–1939) approach to therapy, or **psychoanalysis**, is perhaps the most well-known contemporary approach to therapy. Freud emphasized understanding the unconscious mind as a central tenet of treating psychological disorders. Freud's patients would lie on a couch and talk about their problems through free association or reporting dreams. Psychoanalysis was the dominant approach to treatment until after World War II (Cautin, 2013).

After World War II, substantial funding became available for treatment research. Some of the treatments that emerged shortly after the war were based in derivations of Freud's theory (e.g., psychodynamic therapies), and some were based in theories that were intentionally very different from Freud's (e.g., behavioral therapies, humanistic therapies). By the late 1970s, cognitive therapy had been added, and family and group treatment modalities had become common. The integrative-eclectic perspective—a combination of two or more theories—was already popular among psychologists by 1960 (Norcross & Karpiak, 2013).

Developments in theory and therapy have continued into the twenty-first century. In recent years, feminist/multicultural and positive psychology therapies have emerged, and "third-wave" cognitive and mindfulness therapies have become popular. The integrative perspective remains as popular as ever, a sign that many treatment providers prefer to use more than one of the main types of treatment in their work with clients (Karpiak, Norcross, & Wedding, 2016). Research indicates that some treatments are better than others for certain psychological conditions, levels of severity, and client characteristics, and this might be part of the reason for the lasting popularity of the eclectic-integrative perspective.

THOSE WHO PROVIDE TREATMENT

Professionals who treat people with psychological problems have training as medical doctors (psychiatrists), psychologists, or other professions with specialized mental health training (e.g., social workers, nurses, counselors).

A **psychiatrist** is a medical doctor that specializes in treating psychological disorders. A psychiatrist can diagnose a mental illness such as schizophrenia or depression, prescribe medication, or administer other biomedical treatments, for example, a medical procedure. Some psychiatrists also conduct talk therapy.

A **psychologist** has a doctoral degree (PhD or PsyD) that includes training in diagnosis and treatment of psychological illnesses. Clinical or counseling psychologists may specialize in different age groups (e.g., child clinical) or emphases (e.g., neuropsychology, forensic psychology). A school psychologist has specialized training for working in the school system and may have a master's degree, a PhD, or an EdD. However, school psychologists usually do testing, instead of talk therapy.

Psychiatric social workers, who have a master's in social work (MSW), or **psychiatric nurses**, who have either a Bachelor of Science in nursing or a Master of Science (BSN, MS), have specialized training in psychological disorders. This social worker or psychiatric/mental health nurse may be part of a team in a hospital providing treatment for a patient with psychological disorders. Additional settings for each may be in clinical practice, education, research, or working with families and groups in a community mental health facility. Social workers in particular tend to view psychological conditions, and their treatment, in the context of the individual's social and environmental situation (counseling psychologists do the same).

A **counselor** with a master's degree provides limited psychotherapy for individuals in an outpatient or community setting. They mainly work with issues such as stress related disorders, substance abuse treatment, and family counseling.

APPROACHES TO HELP TREAT PSYCHOLOGICAL CONDITIONS

Treatment providers use varied approaches to help treat psychological conditions. There is now a vast research literature on evidence-based treatments. Major review articles and practice guidelines can help practitioners and consumers make sense of the wide array of options. Many providers identify with one specific theoretical orientation (e.g., Cognitive-Behavioral, Humanistic), while many others identify as Eclectic or Integrative, indicating that they draw from two or more major approaches.

Two things are important to keep in mind for the major approaches outlined in the following lessons:

First, the treatment approach or theoretical orientation of the therapist is only part of what determines treatment effectiveness. The therapy relationship—the working relationship between the treatment provider and the client—is as important as the approach, and "client factors" like readiness to change and pressures and relationships from life outside the therapy session are central in whether the treatment works (Norcross, 2011). While it isn't obvious, the working relationship between practitioner and client is in fact important for successful treatment by medication, not just talk therapy.

Second, for many psychological conditions there are multiple evidence-based medications and psychological treatments that work. For example, treatments for major depressive disorder that have decades of solid research support include medication, interpersonal psychotherapy, and cognitive-behavioral psychotherapy. Other evidence-based treatments for depression include behavioral activation treatment, marital therapy, and others. Many providers practice evidence-based treatment, but it is important not to lose hope if a particular evidence-based treatment does not work for a given client. Clients for whom one type of treatment does not work often will respond well to a second, different evidence-based treatment.

See Activity 1: Treatment Options

CRITICAL THINKING EXERCISES

- Consider the changes that have evolved in the study of psychological science and relate this development to the treatment of psychological disorders.
- Describe the career options available for treating individuals with psychological disorders and the differences between the different types of providers.
- Consider how scientific evidence could support the effectiveness of various treatment options.

LESSON 2

Biomedical Treatments

Biomedical treatments include specific medical procedures and medications that can help to alleviate symptoms of psychological disorders. Often, biomedical treatments are used in conjunction with talk therapies. These treatments are often prescribed by a primary care physician or by a psychiatrist. Properly trained psychologists can also prescribe biomedical treatments in a few states.

PSYCHOPHARMACOLOGICAL TREATMENTS

Medications have been developed to treat the symptoms of many psychological disorders. Generally, these medications work by altering neurochemical systems in the brain to relieve some or all of the symptoms a patient is experiencing. Several broad classes of drugs are used for treatment.

Antipsychotic medications

This class of drugs currently is commonly divided into two broad categories, "first-generation" (also known as neuroleptics or typical antipsychotics) and "second-generation" or atypical antipsychotics. These medications help to reduce serious symptoms (e.g., hallucinations, delusions, paranoia) of schizophrenia in particular. These medications are moderately successful in reducing hallucinations and similar serious expressions of altered behavior.

Essentially, both generations of these drugs act as dopamine blockers. Second generation antipsychotics also act on the serotonin system. The most common trade names of the first-generation drugs are Thorazine and Haldol. Second-generation antipsychotics include, among others, Clozaril and Zyprexa.

Side effects, ranging from dryness of mouth to involuntary jerking movements, typically accompany the use of these drugs. Second-generation antipsychotics often have extreme weight gain as a side-effect. Long-term use of these drugs, especially the first-generation, can result in a condition called tardive dyskinesia. This condition is characterized by uncontrollable repetitive movements, such as facial tics.

Antidepressants

This group of medications is used to treat the symptoms of people who are depressed and/or anxious. Antidepressants increase the presence of serotonin and norepinephrine. It usually takes several weeks before these drugs have a positive effect on the patient.

Monoamine oxidase inhibitors (MAOIs)—this class of antidepressants is used infrequently because people have to adhere to a strict diet, or the drug can cause a toxic reaction.

Tricyclic antidepressants (TCAs)—this class is more effective than MAOIs, with fewer side effects. Alcohol should not be used in conjunction with this medication.

Selective serotonin reuptake inhibitors (SSRIs)—the best-known medication from this class is **Prozac (fluoxetine)**. SSRIs are widely used because they are reasonably effective in treatment of depression and side effects are not as severe as they are with the MAOIs and TCAs. SSRIs also are used to treat panic disorders (Hollander & Simeon, 2003) and an array of other conditions characterized by anxiety.

Mood stabilizers

Lithium helps to reduce the severity of the highs and lows that someone with bipolar disorder typically experiences. Lithium does not act immediately on the symptoms and must be carefully monitored so that the patient does not experience side effects. Immediate treatment of a manic episode might include anticonvulsants such as **Depakote** or an antipsychotic medicine.

Anxiolytics (antianxiety)

Tranquilizers or anxiolytics are used to treat anxiety disorders. Common drugs used today are usually **benzodiazepines (e.g., Librium and Valium).** These drugs produce an immediate calming effect for a person who may be experiencing anxiety. Xanax has become popular for treating panic disorders. Patients can become dependent on these drugs.

Stimulants
Medications like **Ritalin and Adderall** are used primarily for the treatment of symptoms of inattention and hyperactivity.

Different age groups
The vast majority of studies of medication focus on the broad group of adults ages 19 or so through 55-60 or so, and most of the generalizable statements about treatment broadly apply to this group. Children/adolescents and older adults are less commonly included or addressed in treatment studies, yet developmental considerations are very important. Broad examples follow:

Children and adolescents may be prescribed psychoactive medications, although for many medications the potential impact on the developing brain has not been established. The American Academy of Child and Adolescent Psychiatry (AACAP) and the American Academy of Pediatrics (AAP) have developed practice guidelines to help physicians reach treatment decisions about children and teens. These guidelines also reference psychological interventions when they are preferred. Unfortunately for physicians, the two organizations' guidelines aren't always in agreement. For example, the current (2016) AAP guidelines for the treatment of ADHD include the recommendation that the first-line intervention for children under six should be evidence-based behavioral treatment. The current AACAP guidelines are not as clear.

Older adults also require special care in the prescribing and dosing of psychoactive medications. Drug trials often don't include older adults, and they may have different physiological responses to the medications than adults of the ages that are included in the studies. Older adults are also more likely to be taking other medications for other health conditions. Side-effects can have dire consequences (e.g., a fall that can seriously impact the person's life). Conditions like depression are rampant among older adults and medication can be an important part of the treatment regimen. Ideally, physicians with detailed knowledge of and experience with geriatric populations should be consulted.

ELECTROCONVULSIVE THERAPY (ECT)

When ECT was originally introduced, the approach was somewhat barbaric. An electrical current was passed through the brain resulting in convulsions. Today, an anesthetic is administered prior to delivering the shock to make the client more relaxed and to reduce the severity of the convulsions. One of the side effects of this treatment is temporary memory loss of the time period immediately preceding the treatment. This treatment is used only as a last resort for patients who are severely depressed.

OTHER PROMISING APPROACHES

Bright light therapy and Transcranial Magnetic Stimulation (TMS) are examples of biomedical treatments that are accumulating solid research support for treatment of major depressive disorders (Butcher et al, 2014).

Bright light therapy consists of sitting and working or engaging in another activity near a box of bright, specially-designed fluorescent lights for a specified period each day. The mechanism by which this treatment works is not well understood. A rare but serious side effect is a hypomanic state. Originally thought to be useful primarily for depression with onset in the fall or winter, recent research suggests this treatment is useful for non-seasonal depression.

TMS is usually reserved for cases that haven't responded to other treatments, as an alternative to ECT. It involves inducing electrical activity in the cortex, usually over several sessions for two to six weeks. Recent reviews suggest that, unlikely as it seems, this approach is effective.

See Activity 1: Treatment Options

CRITICAL THINKING EXERCISES

- A family member has recently been diagnosed with depression. Discuss the pros and cons of psychopharmacological treatment for depression. The family member is college-aged, how might this complicate the effects of the treatment?
- Consider the pros and cons of psychopharmacological treatment for psychological disorders; include specific disorders as you state your case.
- June is exhibiting behaviors that are interfering with her daily activities. She has been unable to sleep through the night, is constantly fighting with her spouse and has disagreements with her co-workers. She does not appear to be coping with her stress levels and is generally unhappy with her life. Discuss potential treatment options available for her.

LESSON 3

Psychoanalytic, Psychodynamic, and Interpersonal Treatment Approaches

The psychoanalytic approach to therapy, associated with Sigmund Freud, is commonly referenced in popular culture but is not widely practiced anymore. The more modern approaches covered in this lesson continue the emphasis on helping the client develop insight into emotions and interpersonal patterns, but the therapist is much more active than a classical psychoanalyst and the treatment takes substantially less time.

PSYCHOANALYTIC

Building on the hypnosis work of Josef Breuer, **Sigmund Freud** (1856–1939) pioneered psychodynamic therapies. His particular type of therapy has been labeled **psychoanalysis**. Psychoanalysis emphasizes the importance of the unconscious mind. Freud attempted to help people understand, or develop insight, into their unconscious conflicts as a way to relieve neurotic anxiety (Dryden & Mytton, 1999).

Psychoanalysis is an intensive and long-term therapy that may include several sessions per week over a period of up to several years, making it a very expensive treatment. A psychoanalyst helps the patient to discover unconscious conflicts, yet the therapist remains neutral, does not reveal personal information, and does not give advice. Psychologists, psychiatrists, and master's level clinicians can pursue training to become psychoanalysts. Currently, psychoanalysis is not widely practiced in the United States, with its availability limited mainly to large cities.

Psychoanalysis has been highly influential, and important techniques and concepts from psychoanalysis inform many therapists regardless of orientation. These concepts are also present in popular culture. Examples follow:

Free association—during a therapy session, psychoanalysts encourage patients to verbalize any thoughts or feelings that come into their consciousness.

Resistance occurs when patients unconsciously try to censor their thoughts/feelings or sabotage therapy by missing appointments or holding back their thoughts.

Transference occurs when patients treat the psychoanalyst like someone from their past (e.g., a parent). For example, a patient may have unconscious hostile feelings toward an overly domineering parent. When the patient was a young child, a parent may have required the patient to continue an unpleasant set of piano lessons. If, in the course of therapy, the therapist asks the patient why he or she has not completed a project or similar task, then the patient might get angry with the therapist, thus engaging in transference.

Dream analysis—According to Freud, dreams reflect symbolic or unconscious desires. A psychoanalyst asks a patient to describe a dream in as much detail as possible. Then, the psychoanalyst interprets the underlying meaning of the dream. Freud believed that unfulfilled desires that are not expressed consciously during waking hours may be represented in latent content of dreams.

PSYCHODYNAMIC

This term covers a broad array of treatments that descended from psychoanalysis and that emphasize the importance of interpretation and insight in the treatment of psychological conditions. The insight typically includes recognition and understanding of unconscious motivations that have origins in childhood, with a focus on deep understanding of the client's emotions. The therapy relationship remains an important vehicle for revealing the client's patterns. Psychodynamic treatments usually are shorter in duration than traditional psychoanalysis, with clients sitting in chairs facing the therapist and the therapist taking a more active role than an analyst would. While classical psychoanalysis has not been subjected to rigorous outcome research, some psychodynamic treatments have fared quite well in research on outcomes for people with an array of psychological conditions including personality disorders.

INTERPERSONAL

This term covers an array of treatments that emphasize recognition of the interpersonal patterns and the role

they play in the client's psychological well-being. Longer term interpersonal therapies tend to have clear ties to psychoanalytic ideas. They usually include insight into the early attachment and developmental origins of the client's expectations and behaviors in important current relationships. Shorter term interpersonal therapies, like interpersonal therapy (IPT) for Depression (Klerman, Weissman, Ronsaville, & Chevron, 1984), focus on one or two specific current interpersonal patterns that precede or maintain the client's presenting condition—e.g., depressive episodes. Klerman et al.'s IPT is a treatment with substantial research support for depression. A form of the treatment for adolescents, called IPT-A, is demonstrated effective for teens with depression.

CRITICAL THINKING EXERCISES:

- Paying for the treatment of psychological disorders may be a large concern for many individuals and family members diagnosed with a disorder. With a partner or on their own, instruct students to search the internet for methods of paying for the various treatment options provided in this lesson plan. Students should understand what health insurance covers and research mental health parity laws and coverage requirements under the Affordable Care Act and what payment options exist for those without insurance or unable or unwilling to use insurance. Students should present their findings to the class.
- Discuss the progression of traditional psychoanalytic therapy evolving into psychodynamic therapy.

LESSON 4

Humanistic Treatment Approaches

The therapies in this lesson are notable for their focus on a genuine, empathic therapy relationship and intensive attention to the things that happen in the here-and-now of the therapy session. These therapies have contributed substantially, through research on what happens in the therapy session, to our understanding of the therapy relationship. The relationship is now recognized as important across treatment approaches.

HUMANISTIC, CLIENT-CENTERED, AND EXPERIENTIAL APPROACHES

Historically, these therapies comprised the second major approach to emerge after psychoanalysis. The primary focus in these therapies is on assisting the client toward understanding his or her genuine self and true desires.

Carl Rogers developed the early theory associated with many of these approaches. The underlying idea is boldly optimistic—if the therapist can provide the correct conditions, the client will grow toward her or his true potential as a person. The personality theory is one that views humans as naturally moving toward actualization, and the therapist's task is to help the client push through the things society has done to thwart the client's growth toward what is best for him or her. Society and important people around the client set up 'conditions of worth' that a child comes to understand must be met in order to receive love and attention. If a given child's experience is that her or his worth is very conditional, the child internalizes these conditions and eventually becomes unable to identify what he or she truly feels or wants—to separate it from what others want of him or her. The job of the therapist is to assist the client in unearthing her or his true motivations and desires, and once that is done the client will naturally grow toward a genuine life. Although this personality theory is developmental, Rogers' therapy is not past-focused. Indeed, therapists in these approaches focus almost exclusively on the present.

Humanistic therapies emphasize free will of the client and encourage growth or self-actualization. The therapist views the client as the expert, and the therapist as a 'gardener' of sorts whose job it is to set up conditions for growth. This is vastly different from classical psychoanalysis, where the therapist assumed expertise.

Rogers developed the following conditions for therapy. Importantly, he also studied these conditions with a rigor that was unusual at the time. He recorded sessions and looked for associations between these conditions and successful therapy. Client-centered therapists must ensure the following conditions for therapy.

Genuineness
The therapist has to be completely honest and genuine. In essence, therapists model the type of openness they expect from their clients.

Unconditional positive regard
The therapist emphasizes the value of the client by fully accepting the worth of the client. Sometimes clients do things to please others. Unconditional positive regard suggests that the client does not have to please the therapist.

Empathy
The therapist has an emotional understanding of the client. In other words, the therapist can truly understand the perspective of the client.

Traditional humanistic therapies historically have not fared as well as some other approaches in outcome studies, but the conditions Rogers identified and the importance of the therapy relationship as written about by Rogers are now recognized through substantial research as central to success in all kinds of psychotherapy. Indeed, the therapy relationship is at least as important to treatment success as is the type of therapy being practiced.

Modern approaches with origins in Rogerian therapy, including a well-known directive approach to the treatment of substance use disorders called "motivational interviewing," have fared very well in studies of treatment effectiveness. Indeed, motivational interviewing is an evidence-based treatment for substance use disorders.

See Activity 4: Empathy: The Cornerstone of Counseling

CRITICAL THINKING EXERCISES:

- Jacob is 9 years old and has been having difficulties in school, acting out, not concentrating, and not listening to directions from the teacher. His parents recently told him they are getting a divorce. His parents and his teacher decided he would benefit from time with a counselor. Devise a treatment plan for Jacob, utilizing client-centered and/or humanistic treatments.
- Consider the possible limitations of humanistic therapy; include specific disorders that may not be as successfully treated by this therapeutic approach.

LESSON 5

Behavioral and Cognitive Treatment Approaches

Both treatment approaches addressed in this lesson have strong support from treatment outcome research—that is, they are evidence-based treatments for many conditions. The behavioral approach also is very firmly based in the basic psychological science of figures like Skinner and Pavlov. "Cognitive-Behavioral" has become common in the vernacular, and students easily forget that the two terms do not mean the same thing. While many modern therapists use both Behavioral and Cognitive techniques in a course of treatment, it is useful for students to understand the distinctions between the two. Key features of each are spelled out in this lesson.

BEHAVIORAL APPROACHES

Behavior therapy emphasizes changing learned behaviors. Purely behavioral approaches do not require insight into thoughts or feelings. They are short-term treatments focused on current problem behaviors. These approaches evolved out of general principles of classical and operant conditioning that were studied by Watson, Pavlov, and Skinner. Some treatment techniques like systematic desensitization were studied as early as the 1920s (e.g., Mary Cover Jones, Joseph Wolpe).

Common applications of behavior therapy include the treatment of phobias, other anxiety disorders, and PTSD. Behavior therapies and behavioral techniques, taught by therapists and applied by parents, are the most effective treatments for child behavior disorders. Systems-behavioral therapies, where skilled family therapy is paired with behavioral techniques, are among the most effective treatments for serious behavior disorders and substance abuse in adolescents, and a family-implemented behavioral treatment currently is the most effective treatment for teenagers with anorexia nervosa.

These days, due to the dominance of cognitive treatments and the common combination of cognitive and behavioral interventions, people often will mistakenly apply the label "cognitive-behavioral" to purely behavioral therapies. They are not the same. Separate behavioral, cognitive, and cognitive-behavioral therapies have been developed and are effective for conditions like depression.

BEHAVIOR THERAPY TECHNIQUES

Traditional behavior therapy techniques use conditioning (refer students to classical conditioning principles and operant conditioning examples, including negative and positive reinforcement and negative and positive punishment) to alter the client's behavior. The following examples are organized around two common applications of behavior therapy that differ from each other in important ways: treatment of anxiety disorders and of unwanted behaviors.

Anxiety disorders that are characterized by avoidance of feared objects or situations can effectively be treated by **exposure** to the feared cues. In behavioral terms, the person who has the anxiety disorder experiences relief when she or he avoids the feared object or situation. That relief serves as negative reinforcement for continued avoidance. For example, a person with a squirrel phobia will experience significant physiological distress at the thought of a squirrel and may experience full panic if a squirrel is encountered. This is very uncomfortable, and the person will quickly develop uncomfortable anticipation at the thought of encountering squirrels (maybe when planning a trip to the park). The discomfort is relieved by staying away from squirrels and avoiding thinking about them. Thus, avoidance is held in place by negative reinforcement (reinforcement by the removal of fear). Unfortunately, this reduces the likelihood that the person will naturally overcome the fear. Therapists assist clients with phobias and related fear conditions using various approaches to exposure. Exposure also is an important part of effective treatment of Obsessive-Compulsive Disorder (exposure + response prevention) and an exposure therapy ('prolonged exposure') is one of the effective treatments recommended by the VA for Post-Traumatic Stress Disorder.

Systematic desensitization is one common approach to exposure, often conceptualized in classical rather than operant terms. Mary Cover Jones pioneered systematic desensitization or counterconditioning as a method for treating phobias. Later, Joseph Wolpe popularized the treatment. Systematic desensitization used

the principles of classical conditioning by creating new associations for the original phobic stimulus.

- First, an anxiety hierarchy must be developed. This hierarchy is a rank ordering of the anxiety-provoking situation beginning with the least fearful stimulus and ranging to the actual item or situation most feared by the client.
- Second, the client is then trained in relaxation techniques.
- Finally, the stimuli identified in the hierarchy are then progressively paired with the relaxation techniques that the client has learned.

Behavior change
Behavioral treatments are used to eliminate unwanted behaviors (e.g., 'parent training' for children with conduct problems) and to develop and increase desired behaviors (e.g., 'applied behavior analysis' for individuals with autism spectrum disorders). Behavioral treatments are the most effective treatments in both of these cases. Some of the simpler techniques commonly employed in these treatments include:

Positive reinforcement for desired behaviors
Positive reinforcement can be used to encourage people to engage in appropriate behaviors. 'Shaping' of desired behavior—providing social or material reinforcement for progressive little steps toward the behavior—can be used until the behavior is developed. Token economies can be used to reward developed behaviors—these involve giving people a "token," like a poker chip, for performing a desired behavior. The tokens can be exchanged for a desired reward at a later point in time.

Negative punishment for unwanted behaviors
Operant conditioning principles can be used to reduce unwanted behavior. In modern practice, 'positive punishment'—the application of an unpleasant stimulus after an undesirable behavior—is not very common. Instead, negative punishments are used when punishment is needed. One kind of negative punishment involves stopping reinforcement for unwanted behavior. Extinction techniques are applied to reduce or eliminate a behavior that was previously (usually unintentionally) reinforced. For example, a child may receive attention from a parent or from other children for being disruptive or noncompliant. In this case, the attention is reinforcing the child's acting out behavior. If, instead of receiving attention, the child is either ignored or placed in 'time out', the reinforcement (attention) is removed, and this may result in extinction of behavior. Another common kind of negative punishment can be seen in the token system, when tokens are removed after an undesirable response occurs.

See Activity 5.1: Using Psychological Perspectives to Change Habits

COGNITIVE THERAPY

Cognitive therapies are designed to help people change the way that they think about their problems. People can deal with problems by learning to change their thoughts or cognitions. Early cognitive therapies evolved from two perspectives: **rational emotive behavior therapy (REBT, Ellis)** and **cognitive therapy (CT, Beck).** Recently there has been much diversification, and now there are many cognitive treatments that do not have much at all in common with these origins. Examples include the 'third-wave' and mindfulness treatments, which have integrated Eastern thought and practice, and which focus much more on acceptance than on direct questioning of irrational thinking.

Cognitive therapies have been extensively studied for the treatment of depression, and **cognitive-behavioral therapies** (combining behavioral techniques and cognitive components) are useful for many anxiety conditions. Cognitive-behavioral therapy is accumulating an evidence base for children and teenagers with anxiety disorders, down to as young as age 7 or 8 years. Cognitive-behavioral treatments are evidence-based for children and teens with a variety of anxiety conditions including Obsessive-Compulsive Disorder.

Research on cognitive therapies for depression has helped establish the long-term benefits of psychotherapy, including fewer side-effects and better freedom from relapse than is seen with medication treatment. Cognitive therapy also has demonstrated usefulness as an adjunct to medication for conditions like the Bipolar Disorders. **Dialectical Behavior Therapy (DBT),** a newer cognitive-behavioral treatment influenced by Eastern thinking, has demonstrated effectiveness as a treatment for the repeated strong unhappiness and suicidal ideation seen in many people with Borderline Personality Disorder and Bipolar Disorders. Recently, cognitive-behavioral therapy has been recognized as useful in the treatment of many pain conditions.

COGNITIVE THERAPY TECHNIQUES

Rational emotive behavior therapy (REBT)

Albert Ellis is credited with introducing REBT. The premise of REBT or rational emotive therapy (RET) is that people engage in self-talk that is false. If people can change their beliefs, then, according to Ellis, this will produce a change in emotion. The therapist confronts irrational beliefs of the client. For example, the client might believe that he or she must perform perfectly on an exam. The therapist confronts this belief; the client becomes aware of the irrationality of the thought and begins to create a more realistic perspective. The therapist acts primarily as a teacher who helps the client develop skills that will allow the client to think more rationally.

Cognitive therapy

Aaron Beck is credited with developing cognitive therapy and his approach remains widely used in the treatment of depression. Cognitive schemas, methods for organizing the way that we view the world, have evolved into a distorted perception. Examples of these beliefs include minimizing personal accomplishments. In other words, after a major accomplishment, a client may state that "anybody could have succeeded," thus minimizing his or her own success. A cognitive therapist would draw attention to this faulty reasoning of the client. In other words, the therapist would challenge the validity of the statement. Therapy often includes a combination of homework assignments over a series of sessions. In the treatment of depression, a cognitive therapist would assign homework requiring the client to write down automatic thoughts, or the habitual thoughts, that precede feelings of depression.

A structured form requires the client to write down the situation, emotion, automatic thought, rational response, and outcome. In this way, the cognitive schema is brought to the forefront of the client's awareness. Clients often are asked to find support for the automatic thought, and this discussion can occur in the therapeutic context.

See Activity 5.2: Treating Psychological Disorders

CRITICAL THINKING EXERCISES:

- Janice has been diagnosed with agoraphobia; consider treatment options utilizing the behavioral approach to therapy.
- Yvonne has been diagnosed with depression; explain the treatment options available with the behavioral approach to therapy. Include your ideas as to the prognosis of his depression, with this approach to his therapy.
- Johan has been diagnosed with substance use disorder and his psychologist has an eclectic approach to treatment. Explain the psychologists' treatment plan.
- Justify using cognitive therapy to treat depression, include specific data to support your conclusions.

LESSON 6

Ethical and Legal Issues in Treatment

Professional organizations and state licensing boards are in place to help guide professional behavior and protect the public from incompetent or unethical practitioners. The kinds of professionals we have covered in this unit (e.g., psychologists, psychiatrists, social workers, counselors) all have professional organizations for guidance and additionally are subject to oversight from the state. All must engage in continuing education in order to maintain their knowledge and skills and their rights to practice in the state. Unfortunately for the public, many citizens are not aware of the need to seek treatment from a licensed or otherwise verified professional. The term "therapist" is not regulated, meaning anybody can call themselves a therapist and offer services whether or not they have legitimate training and in the absence of a professional ethics code.

ETHICAL ISSUES IN TREATMENT

Professionals should adhere to a set of ethical standards issued by their respective organizations. These standards are in place to provide guidance for professionals and to help protect the public. For example, psychologists should adhere to the ethical principles of the American Psychological Association (APA).

The **APA Ethical Principles of Psychologists and Code of Conduct** is quite detailed and covers an array of professional situations including provision of therapy, teaching, research, and conducting assessments. General aspirational principles include working for the best interest of clients and proactively avoiding causing harm to clients, being honest, accurate, and responsible, concerned with fairness, and attentive to the rights and personal dignity of clients.

Examples from the Code of Conduct, applied to the therapy setting, include:

- Recognizing the limits of one's competence and offering services only within the bounds of one's expertise (e.g., not offering forensic or neuropsychological services, or services to children and adolescents, unless extensively trained for these settings or populations)
- Clarifying one's role with a client and not engaging in dual role relationships that could impair objectivity in therapy (e.g., not providing services to a friend or neighbor, not getting into a personal relationship with a client)
- Maintaining confidentiality (e.g., the psychologist should not reveal the personal information of a client, and indeed should not even reveal that a person is receiving services from them). This is also required under HIPAA and other laws.
- Informed consent—the client should be informed before treatment begins of the type of treatment to be provided, its cost, how long it is likely to take before some results are seen, basic information about effectiveness, and clear discussion of confidentiality and its limits. Freely given (voluntary) informed consent to treatment is important.

In addition to ethical standards, professionals must adhere to legal stipulations governing the practice of psychology. One example of the nexus of law and ethical code relates to the **right to privacy**, which is granted by the U.S. Constitution. Although this right to privacy is a legal mandate, specific application of this right to privacy is specified in the APA ethics code (Koocher & Keith-Speigel, 1998). Essentially, practitioners should be sure that they keep all information confidential. Information about a client should be released only under very specific circumstances, and the client has a right to know, in advance, about the conditions under which information will be released. For example, if a client tells a psychologist that (she) he has serious, feasible plans to hurt someone, the psychologist must break confidentiality. The exact details of what the psychologist must do vary from state to state, so psychologists must be aware of relevant state laws.

Excellent resources for research on ethical issues in psychotherapy will be found at the American Psychological Association and the American Psychiatric Association websites.

See Activity 6: Choosing a psychotherapist

CRITICAL THINKING EXERCISES:

- Consider and explain specific ethical issues a psychologist may confront when treating a client with symptoms of a substance use disorder.
- Dr. Shaw is a psychologist with the police department; explain a few ethical issues she may confront as she works with inmates housed in their jail.
- Instruct students to research local options for treatment within their community. Use this research to prompt a class discussion of treatment options.

ACTIVITIES

ACTIVITY 1

Treatment Options

Mary Spilis, Sylvania Northview High School, Sylvania, Ohio (retired)

Instruct students to create poster boards to display either in their psychology classroom or in their school cafeteria explaining the various treatment options available in their community.

Note: This activity could also be a culminating activity at the end of the lesson plan.

The posters should include, but are not limited to, the following information. It should also include a section mentioning different career options in clinical or counseling psychology:

- The name of the service providers
- The credentials of the service providers
- Areas of specialization of the service providers
- Location of the facility
- Ages of the clients
- Specific psychological disorders treated at the facility
- Services provided, inpatient and/or outpatient
- Payment options

ACTIVITY 4

Empathy: The Cornerstone of Counseling

Peter S. Fernald, University of New Hampshire
L. Dodge Fernald, Harvard University

Reading a brief passage taken from an actual counseling session, the instructor plays the role of a sad and struggling client. Students are provided with 10 statements that a counselor might think or say in reaction to what the client said. The task is to identify which statements are empathic and which are not empathic. The activity provides students with the opportunity to imagine themselves in the role of counselor and to consider what they might or might not say, assuming their primary intentions were to be empathic.

Concept

This activity addresses the concept of empathy, considered by counselors to be a critical, if not the most essential, feature of any approach to counseling. In the writing component, the concept of projection is compared and contrasted with the concept of empathy. The activity is appropriate for a general counseling, advanced undergraduate, or graduate course.

Materials

Copies of the handout *Listening Empathically* (*Handout Master: Listening Empathically* is included at the end this activity). The handout includes a statement by a client and 10 therapist responses (or thoughts) that students evaluate for empathic quality. Instructions to the students, which are presented in the third paragraph of the following section, may also be included in the handout.

Description

Indicate that a major aspect of any type of counseling or psychotherapy is empathic listening. Mention too that, for some approaches, the counselor's empathy is both central and critical (e.g., Kohut, 1982; Rogers, 1951, 1961). Then tell the students that the activity that they are about to engage in will help them better understand both the nature and difficulties of listening empathically.

Define empathy as the act of adopting the client's perspective or, metaphorically speaking, the act of walking in the client's psychological shoes. The counselor's task, Rogers (1951) said, is to assume, in so far as he or she is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he sees himself, to lay aside all perceptions of the external frame of reference while doing so, and to communicate something of this empathic understanding to the client.

Provide each student with a copy of the handout *Listening Empathically*. Allow the students 2 or 3 minutes to read the handout. Then read the following instructions, which may also be included in the handout: "As you listen to me role-play a client, pretend you are a counselor or a therapist. Your task is to adopt my—that is, the client's—perspective. Try to see the world through the client's eyes. Assuming you are able to do this, imagine which of the 10 statements listed on the bottom half of this handout might run through your mind as I speak for the client. Place a check mark by each of these statements. Remember, you are to check only those statements that indicate you adopted the client's perspective."

Next, assuming the client role, read the statement aloud with feeling so that the students have a clear sense of your sadness and struggle. After the reading, ask the students to check those statements that indicate an empathic perspective. Allow the students about 5 minutes to complete this task.

Students' interest and involvement are substantially enhanced if they are organized into small groups with instructions to arrive at a consensus for each therapist statement. However, this procedure, which is not essential, requires a greater amount of time.

Discussion

Ask the students (or a representative of each small group) what their reactions were to the counselor's first statement. Was it empathic? Does it indicate that the counselor adopted the client's perspective? Some students will take the position that the statement is empathic. Other students will disagree, and the latter students are correct. The first statement is not truly empathic, because the client, even though he obviously struggles to express himself, indicates no concerns about getting started talking. The discussion may become quite spirited, as some students may insist that the counselor's desire to

help the client indicates empathy. It is important that these students understand the distinction between wanting to be helpful and listening empathically.

Proceed to the second statement and again ask the students whether or not it is empathic. Most students indicate this statement also is not empathic, and they are correct. The client's statement may suggest indecisiveness, but the client indicates no specific concerns about indecisiveness. Also, he makes no reference to any instances of indecisiveness. The statement, therefore, represents the counselor's concern and has little or nothing to do with anything the client expresses. It reveals the counselor's agenda, possibly his or her theoretical perspective. The statement clearly is not an instance of empathic listening.

Continue the discussion by proceeding through the remaining statements.

Statements 3, 6, 7, 8, and 10 indicate empathic listening. The other five statements are not empathic. Discussion of the first few statements may be a bit lengthy. However, as the students gain a better understanding of what it means to listen empathically, discussions of subsequent items take less time.

Writing Component

Ask students to write a statement in which they define, compare, and contrast two concepts: empathy and projection. Possible answers and discussion might focus on the ways in which the two concepts both overlap and are distinct. They overlap in the sense that both involve one person attempting to understand the motives and emotions of another person. It has been suggested that projection is the basis of empathy. In so far as a therapist's emotional reaction to a particular circumstance—for example, sadness or anger over the death of a parent—is the same as the client's reaction, projection may prove a basis for empathy.

However, the concepts actually are quite distinct. According to a psychoanalytic perspective, projection occurs when one erroneously attributes his or her own unwanted thoughts, motives, or feelings to another. The more general definition of projection is a perception influenced by one's needs, wishes, and hopes.

Whether we refer to the classical or more general definition, projection differs substantially from empathy. Suppose, for example, that the therapist responding to the passage in this activity had many unhappy childhood experiences that he or she wished had never occurred. In such a case, statement 9 would be regarded as a projection or, more specifically, as countertransference.

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HANDOUT MASTER

Listening Empathically

Client: I don't feel very normal, but I want to feel that way. I thought I'd have something to talk about—then, it all goes in circles. I was trying to think what I was going to say.

Then, coming here, it doesn't work out. I tell you, it seemed that it would be much easier before I came. I tell you, I just can't make a decision. I don't know what I want. I've tried to reason this thing out logically—tried to figure out which things are important to me. I thought that there may be two things a man might do. He might get married and raise a family. But if he was just a bachelor, just making a living—that isn't very good. I find myself and my thoughts getting back to the days when I was a kid, and I'd cry very easily. The dam would break through. I was in the army 4-1/2 years. I had no problem then, no hopes, no wishes. My only thought was to get out when peace came. My problems, now that I'm out, are as ever. I tell you, they go back to a long time before I was in the army. I love children.

When I was in the Philippines—I tell you, when I was young I swore I'd never forget my unhappy childhood—so when I saw these children in the Philippines, I treated them very nicely. I used to give them ice cream cones and treat them to movies. It was just a period—I'd reverted back—and that awakened some emotions in me I thought I had long buried. (A pause. He seems very near tears.) (Rogers, 1951)

1. I wonder if I should help you get started talking.
2. Why your indecisiveness? What could be its cause?
3. It's really hard for you to get started talking.
4. What is meant by your focus on marriage and family?
5. The crying and the dam sound as though there must be a great deal of repression.
6. Decision making just seems impossible to you.
7. You want marriage, but it doesn't seem to you to be much of a possibility.
8. You feel yourself brimming over with feelings reminiscent of your childhood.
9. At some point, you will probably need to dig into those early unhappy experiences.
10. Being very nice to children has somehow had meaning for you.

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ACTIVITY 5.1

Using Psychological Perspectives to Change Habits

Rob McEntarffer, formerly of Lincoln Southeast High School, Lincoln, Nebraska

Introducing psychological perspectives can be a dry lecture and potentially confusing to students. It is usually done toward the beginning of the semester, and the students have little context and few examples to use to make sense of the perspectives. This activity gives them context by asking them to analyze a personal habit using psychological perspectives. The students may also keep a journal documenting their habit changing in which they analyze the effectiveness of their intervention and choice of perspective.

Concept

This activity demonstrates the relevance and applicability of psychological perspectives to students' lives.

Materials

- Lecture on psychological perspectives (or student knowledge of the perspectives). The perspectives that work best for this activity are behavioral, cognitive, biological, and social-cultural. The activity can be modified to include the psychoanalytic and humanist perspectives as well.
- Why the Heck Do I Do That? (Handout Master A)
- Habit Journal (Handout Master B)

Description

After communicating information about the perspectives to the students, hand out the *Why the Heck Do I Do That?* sheet. This can be completed in class or given as homework. Give the students some examples of habits that can be analyzed, and get some sample analysis from student volunteers. When the students are finished, ask them to pick the perspective that best explains their habit. Again, discuss some volunteered examples. After students choose their perspective, ask them to use their *Why the Heck Do I Do That?* sheet and design an intervention in order to change their habit. Discuss a personal example of your own (it's a good idea if you complete the sheet and design your own intervention before the lesson and do this activity along with your students).

Explain to the students that you would like for them to try to change their habit over the next 2 weeks. You should make this a voluntary assignment. Forcing the students to try to change a habit would encourage cheating on the journal and wouldn't be useful for the coerced student. Hand out the *Habit Journal* and explain how to keep the journal on their habit changing. After the 2 weeks have passed, you can discuss with your students how the habit changing went. The class can discuss which perspectives and interventions were most effective for certain types of habits. You can also encourage your students to continue their habit changing for the rest of the semester if it was helpful to them.

Discussion

Students are sometimes very skeptical about psychological explanations for behavior. They see accused criminals pleading insanity and assume that psychology is an excuse to let people out of responsibility for their actions. This activity attempts to demonstrate the value of psychological explanations for behavior by getting the students to examine their own behavior using psychological terms and concepts. By applying the perspectives to themselves and seeing first-hand how intractable and resistant to change some behavior is, the students should gain a clearer understanding of some of the real causes of human behavior. The activity also helps students better understand psychological perspectives by applying them to a real-world example that has relevance to the student.

Writing Component

The students complete the *Why the Heck Do I Do That?* sheet, and then keep a 2-week journal about their habit changing. Writing the journal should show the students the process of changing behavior and its level of difficulty. It directly relates the perspectives to the students' own experiences, and it helps remind the students of their intervention and assignment.

HANDOUT MASTER A

Why the Heck Do I Do That?

Think of a habit you would like to change. It can be a bad habit you want to get rid of, or a good habit you want to acquire. Write here about the habit. What is it? Why do you want to get rid of it or acquire it? What causes the habit?

Now, take your habit and do some role-playing with it. Look back at your notes to understand what the following terms mean. How would a psychologist from each of these perspectives explain the cause of your habit? How would they treat your habit; help you stop the habit or acquire it?

Behavioral:

Cognitive:

Biological:

Social-Cultural:

HANDOUT MASTER B

Habit Journal

For the next 2 weeks, please try to change your habit. Use the perspective and intervention you designed in class. Please keep a journal about how your habit breaking is going. Write something every day; whether you managed to go without your habit, whether you forgot or gave into temptation, whether you managed to keep up your habit, etc. Basically, how is your intervention working? How does the psychological perspective you chose apply to your current situation with your habit?

ACTIVITY 5.2

Treating Psychological Disorders

Allyson J. Weseley, Roslyn High School, Roslyn, New York
Chuck Schira, Portage Central High School, Portage, Michigan

Students find psychological disorders and treatments fascinating, but they often confuse them. This activity, written for classrooms of between 15 and 30 students, requires students to consider diagnoses for clients based on short case histories and to recommend appropriate treatments. Students are challenged to apply the information they have learned in this engaging way to review information taught in the disorder and treatments units.

Concept

Students will learn to use their knowledge of psychological disorders to consider diagnoses for mock clients and will evaluate the effectiveness of different perspectives in treating different disorders.

Materials

- Index cards (20 in total, 5 of one color, 5 of a second color, and 10 of a third color)
- Case Histories (See appendix)

Description

First, write each of the following five terms on one index card each of the same color: *humanistic*, *biomedical*, *cognitive*, *behavioral*, and *psychoanalytic*. Label these five cards *Perspective Cards*. Next, cut out the 10 case histories (*Appendix: Case Histories*) and post each onto an index card (use different color cards for this set). Label these cards *Case History Cards*. The disorders described in the case histories are as follows:

Ken	Obsessive-Compulsive Disorder
Karl	Major Depressive Disorder
Julio	Schizophrenia (2 of the symptoms: delusions/ false beliefs and disorganized speech)
Brian	Dissociative Identity Disorder
Gerri	Functional Neurological Symptom Disorder
Keshona	Social Anxiety Disorder
Ikimba	Generalized Anxiety Disorder
Samantha	Post Traumatic Stress Disorder
Tuan	Antisocial Personality Disorder
Don	Bipolar Disorder

Finally, write each of the following five terms on one index card, each, for the Bonus Round (use a third color for this set): *Major Depressive Disorder, Social Anxiety Disorder, Posttraumatic Stress Disorder, Obsessive-Compulsive Disorder, and Schizophrenia.*

How to Play: *Round 1*

Divide the class into five teams and have each team select a Perspective Card. Each team will represent that perspective for the entire first round. Have each team choose a representative to sit in the front of the class. These representatives will be the first players. Determine the order (i.e., which representative will go first, second, etc.).

Representatives take turns selecting a Case History Card, reading it aloud, and attempting to provide the correct specific diagnosis. A correct diagnosis earns the team 1 point. If the diagnosis is incorrect, the next team's representative gets the chance to diagnose.

Once a correct diagnosis is made, the team can earn an additional point by having its representative name or explain an effective treatment and the perspective with which it is associated. As the instructor, you will judge whether the explanation merits the point. If you rule that the treatment suggested is inappropriate, the next team's representative gets the chance to suggest a proper treatment.

An extra point is awarded if a team representative provides an appropriate treatment from the perspective (determined by the card drawn at the beginning) it represents. Once an appropriate treatment is suggested, the Case History Card is discarded. Team representatives who have participated return to their teams, with different representatives taking a turn up in front.

The activity continues with the next team representative (following the previously established order) choosing a Case History Card.

Bonus Round

One volunteer from each team is named the "client." Each client selects one of the face-down Bonus Round cards and has 45 seconds to describe the symptoms of the disorder to her or his team members. **Clients must be sure to only describe their symptoms, not to act them out in any way. The team's goal is to guess the disorder being described.**

During the 45-second period, team members may interrupt and ask questions. A correct diagnosis of the disorder within 45 seconds is worth 2 points. After each team has participated, the activity is over. The team with the most points wins.

Additional Notes

As the instructor, you must use your own judgment regarding specificity of correct treatments. For instance, the author would not accept "drugs" as a treatment for schizophrenia. Students must specify a type of drug (e.g., phenothiazine), but not the name of a specific drug.

Stress to students that they are not prepared to diagnose those with psychological disorders. Also stress that clinicians do not diagnose clients on the basis of a brief description. Finally, alert students to the impact of labeling people as mentally ill. Of course, explain to students that cheating (e.g., providing a team representative with an answer) will result in a point deduction.

Discussion

The students' level of activity performance will indicate how well they have mastered the subject matter. Interrupt the activity as necessary to dispel confusion. Also, the activity may be shortened or extended.

Use the following questions to facilitate the discussion at the activity's conclusion:

1. What kinds of therapy are best for what kinds of disorders?
2. In selecting a therapist, what are the advantages and disadvantages of choosing one who is a strict adherent to a particular perspective versus a more eclectic practitioner?
3. Clients often have symptoms of more than one disorder. How may this fact affect the treatment process?

Writing Component

Select a comic book super hero (such as one of the Marvel comic heroes like Iron Man), consider a psychological disorder they have manifested. Describe the signs and symptoms they are exhibiting, decide upon a diagnosis, determine treatment options and explain the process of treatment.

This is a great activity to culminate the abnormal units, disorders and treatment, it provides a writing component for the students to be creative and display all of their expertise on these topics.

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APPENDIX

Case Histories

Cut out, separate, and paste each of the following descriptions onto a 3- by 5-inch index card.

Ken is plagued by constant worries that what he has planned will not occur as scheduled. He makes hundreds of to-do lists each day and often checks these lists to make sure they are correct. Ken incessantly reminds his colleagues of upcoming deadlines, sometimes 15 or 20 times each day.

Karl, a star basketball player, has recently lost interest in playing or talking about basketball. He has persistent feelings of sadness and worries he is not good at anything anymore.

Julio believes he is an alien who has been left behind on Earth by his "pod." He is often difficult to understand, because he speaks frequently in rhyme and makes up his own words.

Brian appears to be a mild-mannered 20-something, but he sometimes believes he is a teenage female named "Suzy" who is a member of a high school dance team. At these times, he dresses in various matching outfits, carries pom-poms, and practices various dance routines. Brian is confused about why he sometimes awakens dressed in strange clothing.

Driving back from a concert, Gerri fell asleep at the wheel and crashed her Jaguar convertible. Her best friend perished in the crash. Ever since, although doctors can find nothing physically wrong, Gerri has been paralyzed in the arm with which she was steering.

Keshona is terrified of speaking in public. Although highly knowledgeable and competent, whenever she has to address a gathering of adults, her heart pounds, and her mouth gets dry.

Tuan has been arrested on numerous occasions for disturbing the peace and for illegally producing and selling alcohol and drugs to minors. Although a number of his clients have died from overdoses, he feels no remorse.

While she was on a visit to the Midwest, Samantha's residence was demolished by a tornado. Ever since, she has been plagued by terrible nightmares and occasional flashbacks.

Don goes through periods when he feels he just can't lose. He goes on gambling sprees, launches new get-rich-quick schemes, and engages in promiscuous behavior. At other times, he feels so down that he can't even get out of bed. Life seems purposeless.

No matter what he is doing, Ikimba always feels a little tense. The apprehension has no apparent cause. Even during weekends and vacations, he experiences constant uneasiness.

ACTIVITY 6

Choosing a Psychotherapist: Activity and Handout

Sue Frantz, Highline College

For my Intro Psych course, I spend a lot of time thinking about what the future medical professionals, engineers, business leaders, and politicians taking my classes need to know about psychology. In the disorders chapter, I ask students to raise their hands if they, a friend, or a family member has been diagnosed with a psychological disorder. About ⅔ of the hands go up. My students or someone they know could benefit from seeing a psychotherapist. Intro Psych textbooks include information about what psychotherapy is, but how often do they cover how to find a psychotherapist?

The American Psychological Association (APA) provides a "how to choose a psychologist" page, a page that "may be reproduced and distributed for noncommercial purposes with credit given to the American Psychological Association." At minimum, provide a link to this page in your course management system: https://www.apa.org/helpcenter/choose-therapist. If you have the resources, print and distribute to your students.

If time allows, this topic lends itself to a jigsaw classroom. Divide your students into 6 groups. If that would make your group size too large (say, over 5 per group), divide your students into 12 or 18 groups. Each group gets one of the "questions to ask" a psychologist bullets from the "how to choose a psychologist" page with the following instructions.

Group A

"Are you a licensed psychologist? How many years have you been practicing psychology?"

Using the Internet, find out what it takes to become a licensed psychologist (in our state, province, country—use whatever geographic dimension applies to your location). If licensure includes a doctoral degree or internship accredited by the American Psychological Association (APA), find out what a university or internship needs to do to receive that accreditation.

Group B

"I have been feeling (anxious, tense, depressed, etc.) and I'm having problems (with my job, my marriage, eating, sleeping, etc.). What experience do you have helping people with these types of problems?"

Refer to the examples at the end of the "how to choose a psychologist" webpage. How would each of the people in these examples ask this question. Identify five problems that are commonly experienced by students. For each problem, write out how a student could phrase the issue to a practicing psychologist.

Group C

"What are your areas of expertise—for example, working with children and families?"

Referring to this chapter of your textbook, what areas of expertise might a practicing psychologist identify? (Hint: think populations of people who may benefit from psychotherapy and the types of issues people may have.)

For each of the examples given at the end of the "how to choose a psychologist" webpage, what areas of expertise should the practicing psychologist have?

Group D

"What kinds of treatments do you use, and have they been proven effective for dealing with my kind of problem or issue?"

Using the information in the textbook chapter, identify at least five different treatments that a practicing psychologist might use.

For each of the examples given at the end of this page, identify the treatment or treatments that may be appropriate.

Group E

"What are your fees? (Fees are usually based on a 45-minute to 50-minute session.) Do you have a sliding-scale fee policy?"

Using the Internet, identify the typical fees charged by practicing psychologists in our area. What is a sliding-scale fee and how does it work? How often can one expect to attend therapy sessions? How many sessions can one expect to attend?

Group F

"What types of insurance do you accept? Will you accept

direct billing to or payment from my insurance company? Are you affiliated with any managed care organizations? Do you accept Medicare or Medicaid insurance?"

This document provides more information about insurance and psychotherapy: http://www.apa.org/helpcenter/parity-guide.pdf. Summarize the major issues to consider. What questions should you ask your insurance carrier before contacting a practicing psychologist?

Mingle amongst the groups, answering any questions that arise.

After the groups have finished answering their questions, students are to make sure that everyone in their group knows the answers. Reconfigure the groups so that one person from each A to F group is in a new group together. One relatively quick way to do this is to give the members of each group a different colored index card or half sheet of paper. Group A, for example, gets aqua, Group B get dark blue, Group C gets cherry red. When the groups get split up and reassembled, members of the new group will hold up their colors. There should be at least one person for each of the six colors in the new group. Any group who is missing a color can yell for that color: "We need an aqua!"

In their new groups, each student reports what they learned about their bullet point. Again, mingle amongst the groups, answering questions.

After students have finished sharing within their groups, bring the class back together, and ask students if they feel more informed about choosing a psychotherapist than they did before class started. Answer any remaining questions.

Now that students know the questions to ask a psychotherapist, they still need to find a psychotherapist to ask. For people who live in the US or Canada, APA offers a helpful locator service: https://locator.apa.org/. Use the drop-down menu to select a US state, a US territory, or a Canadian province. Visitors are redirected to the websites of those state, territorial, or provincial psychological organizations that have their own searchable provider databases.

Remind students that one way they may be able to help a loved one is by, with the loved one's permission, doing the legwork to find a practicing psychologist for them. When you're struggling and everything feels impossible, finding a practicing psychologist could feel like an impossible task (Murphy, 2018).

CRISIS TEXT LINE

For immediate help, for themselves or a loved one, students can contact the Crisis Text Line.

In the US, text HOME to 741741.
In Canada, text HOME to 686868.

The Crisis Text Line is coming to the UK in 2018-2019 (see https://www.crisistextline.uk/faqs).

For students who are looking for volunteer opportunities in the US, Canada, or the UK, the Crisis Text Line is looking for volunteer counselors. Each volunteer receives a "30-hour web-based training" and is asked to commit to four hours of service each week with an overall 200-hour commitment.

Also consider sharing local crisis hotline numbers with your students. A valuable service-learning-type project for your students would be advertising on your campus the Crisis Text Line as well as local hotlines or other national hotlines.

Activity credit: Macmillan Learning

SUGGESTED RESOURCES

WEB RESOURCES

Web resources that are appropriately reviewed can be helpful to students.

APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD)
https://www.apa.org/ptsd-guideline/index.aspx

APA Code of Ethics for Psychologists
http://www.apa.org/ethics/code/index.aspx

APA Psychology Help Center
http://www.apa.org/helpcenter/index.aspx

APA Psychology Help Center: Understanding Psychotherapy and How it Works
http://www.apa.org/helpcenter/understanding-psychotherapy.aspx

APA Topics: Therapy
http://www.apa.org/topics/therapy/

APA Topics: Different Approaches to Psychotherapy
http://www.apa.org/topics/therapy/psychotherapy-approaches.aspx

Effective Child Therapy: Created by the Society of Clinical Child and Adolescent Psychology (APA Division 53)
https://effectivechildtherapy.org/

National Alliance on Mental Illness
http://www.nami.org

National Alliance on Mental Illness: Commonly Prescribed Psychotropic Medications
https://www.namicollier.org/849/

National Institute of Mental Health
https://www.nimh.nih.gov/index.shtml

National Institute of Mental Health: Help for Mental Illness
https://www.nimh.nih.gov/health/find-help/index.shtml

Recognition of Psychotherapy Effectiveness (APA Resolution)
http://www.apa.org/about/policy/resolution-psychotherapy.aspx

Society of Clinical Psychology (APA Division 12): Psychological Treatments (alphabetized list)
https://www.div12.org/psychological-treatments/

VIDEO RESOURCES

Three approaches to psychotherapy with a female client: The next generation
http://www.apa.org/pubs/videos/4310889.aspx

Three approaches to psychotherapy with a male client: The next generation
http://www.apa.org/pubs/videos/4310890.aspx

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